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ORIGINAL ARTICLE

Development of a portuguese version of the *Psychotherapy Process Q–Set**

Fernanda Barcellos Serralta[I]; Maria Lúcia Tiellet Nunes[II]; Cláudio Laks Eizirik[III]

[I]Psychologist. MSc. in Clinical Psychology, Pontifícia Universidade Católica do Rio Grande do Sul (PUCRS), Porto Alegre, RS, Brazil. PhD student in Psychiatry, Universidade Federal do Rio Grande do Sul (UFRGS), Porto Alegre, RS, Brazil. Associate professor, Psychology, Universidade Luterana do Brasil (ULBRA), Canoas, RS, Brazil
[II]Psychologist. PhD in Psychology, Free University of Berlin, Berlin, Germany. Professor, Psychology, PUCRS, Porto Alegre, RS, Brazil. Coordinator, Graduate Program in Psychology, PUCRS, Porto Alegre, RS, Brazil
[III]Psychiatrist. PhD in Medicine, UFRGS, Porto Alegre, RS, Brazil. Associate professor, Department of Psychiatry and Forensic Medicine, UFRGS, Porto Alegre, RS, Brazil. Training analyst, Sociedade Psicanalítica de Porto Alegre, Porto Alegre, RS, Brazil. President of the International Psychoanalytic Association (IPA)

Correspondence

ABSTRACT

INTRODUCTION: In Brazil, psychotherapy research is in its early development; there are no systematic studies of the therapeutic process, and there are few available measurement instruments for researchers interested in this field. **OBJECTIVE:** To develop a Portuguese version of the Psychotherapy Process Q–Set. **METHOD:** The development of a Portuguese version of the Psychotherapy Process Q–Set involved four stages: translation, back translation, evaluation of semantic equivalence and discussion of the results by the authors. Five raters were trained to apply the instrument. During the training, a field diary was used to record difficulties identified in task execution and to subsidize complementary data. Thereafter, the Psychotherapy Process Q–Set was applied to seven sessions of a short–term psychodynamic psychotherapy to examine agreement between referees. **RESULTS:** The Portuguese version of the Psychotherapy Process Q–Set presented good semantic equivalence with the original. The assessment of interrater reliability had a satisfactory result. It is worth stressing that applying the Psychotherapy Process Q–Set requires study, time and reflection. The discussion with raters pointed to the need of reviewing the application manual concerning the clinical examples. This will be performed in the near future to minimize the discrepancies observed in the understanding of some concepts and to better adjust them to the Brazilian reality. **CONCLUSIONS:** This study provides a Portuguese version of the

Psychotherapy Process Q–Set, a versatile instrument that can be used in different contexts to quantitatively describe the therapeutic process of different psychotherapies in clinically significant terms.

Keywords: Translation, semantic equivalence, instruments, reliability, therapeutic process, psychotherapy.

Introduction

There is considerable consensus that the impulse to research in psychotherapy has its origin in the criticism made by Hans Eysenck[1] that there was no evidence confirming the fact that psychotherapies were more effective than other intervention methods. Repercussion of that article was almost immediate, generating a large number of studies on the efficacy of psychotherapies and psychoanalysis. Therefore, for more than four decades, researchers produced considerable evidence on the results of psychotherapies,[2] so that nowadays the generic question whether psychotherapies are efficient or not is no longer a dominant concern.[3,4] Since the past decade, new problems have occupied researchers, such as which psychotherapies work better for which patients?[5] And which aspects, methods and factors contribute to changes in psychotherapy?[6]

Russell & Orlinsky[7] divide the history of research in psychotherapy into four stages, and the current one presents an increasing interest in studying the therapeutic process. Concerning psychoanalytic research specifically, Wallerstein[8] describes four successive generations. The first generation started with Coriat's survey on therapeutic results, in 1917, and is characterized by survey studies, based on "opinions" and without bias control. The second generation started in the late 1960's in Europe and USA: these are large–scale, prospective and comparative studies, including multiple measures and more rigorous treatment of variables. The third generation, contemporary to the second, combines process assessment with therapeutic results by applying multiple measures throughout time. The fourth generation is *in statu nascendi* and focuses its questioning on the nature of the therapeutic process, which performs an in–depth investigation using audio and video recordings.

The microscopic study of the therapeutic interaction, in complete sessions or in fragments of recorded and transcribed sessions, is still "music to the future,"[8] as can be observed in the review on psychoanalytic research carried out by Fonagy et al.,[9] in which, out of 50 projects included, only nine were "pure" process studies and six were process/result studies. Actually, many studies classified as process are in fact microstudies of results.[4]

The main goal of studies on therapeutic process is to understand how changes take place throughout the treatment,[2] i.e., identify the mechanisms of therapeutic action. To do so, researchers apply qualitative and quantitative methods to examine patterns concerning the therapist/patient interaction and communication through psychotherapy sessions, relating them to positive or negative therapeutic episodes, as well as to clinical change.[10]

Since its early stages, psychoanalysis has studied the therapeutic process from a clinical perspective. Therefore, it is not a coincidence that many of the instruments developed over the past decades for a systematic investigation of the therapeutic process have psychoanalytic oriented authors, among them: the Fundamental Repetitive and Maladaptative Emotion Structures (FRAMES),[11] the Core Conflictual Relationship Theme Method (CCRT)[12] and the Psychotherapy Process Q–Set (PQS),[13] which will be analyzed in this study.

PQS, as the other instruments mentioned above, is based on the literal transcription of recorded therapy sessions, an issue that has raised controversies between clinicians and psychoanalytical researchers for decades.[9,14–16]

In Brazil, psychotherapy research is in its early development, and there are no in–depth systematic studies of the therapeutic process. Debates on the use of a recorder are practically inexistent, except for a few cases.[17,18] Also, there are few researchers investigating the effects of process variables on therapy results. In this sense, the studies by the Center of Studies and Research on Brief Psychotherapy using the Operational Adaptive Diagnostic Scale[19] and Marcolino's research[20] on

the impact of therapeutic alliance on brief psychotherapy stand out. In Rio Grande do Sul (Southern Brazil), there are no quantitative studies investigating the dimension of therapeutic processes/results. However, some recent studies on patient's factors associated with ability of forming therapeutic alliance[21] and on the association between therapeutic alliance and transference[22] manifest interest in this issue. There is also an increased interest, among researchers, in developing Brazilian versions of instruments assessing factors (patient's or patient/therapist bond) that integrate or influence psychotherapy process, such as transference,[22,23] countertransference,[24] therapeutic alliance[25] and defense mechanisms.[26] Such initiatives are essential for the development, enhancement and expansion of research on psychotherapy in our country.

A detailed study of the therapeutic process allows the development and assessment of explanatory models of therapeutic action.[13] It also provides the possibility of analyzing Dodo's hypothesis or verdict,[27] which claims that different psychotherapies are equally effective†. Although corroborated by many studies, this hypothesis has been questioned by some researchers, who consider psychotherapy equivalence a myth that reflects the limitations of variables being investigated[28] and of study designs and procedures.[29,30] In fact, it seems reasonable that different techniques produce similar results when means by which results were produced are not assessed.[4] Therefore, the notion that non–specific factors (for example, therapeutic alliance) are key elements to explain therapeutic results is partly due to the lack of systematic studies investigating the different effects of different therapies or that identify the relationship between different therapeutic interventions and results.[30]

Further use by Luborsky et al., in 1975, became famous in the literature and is a reference to results of numerous comparative studies that fail to demonstrate significant differences in results of different psychotherapies. In general, it is considered that technical factors (specific) distinguish certain types of therapies, whereas common factors (unspecific), such as the relationship between therapist and patient, are always present. In fact, many studies have demonstrated that therapeutic alliance is an important predictor of therapeutic results in different psychotherapies.[31–33] However, there are no sufficient studies to clarify **how** such factors, specific or common, contribute to changes in psychotherapy.[34]

PQS‡ was developed with the aim of understanding the role of different factors involved in the therapeutic process. This instrument, applicable to the therapeutic session recorded in audio and/or video (analysis unit), promotes a detailed and comprehensive description of elements in the therapeutic process in clinically relevant terms and, at the same time, compatible with quantitative and comparative analysis, thus contributing to overcome the historic dissociation between clinical activity and research on psychotherapy.[13] PQS has been successfully used to empirically establish causal relationships between therapeutic process and psychic change in single or multiple case–study designs.[9] Based on those studies, Jones[13,35] formulated the construct "interaction structures" (manifest, behavioral and emotional aspects of transference and countertransference) and developed a theory of therapeutic action (of psychoanalysis and psychoanalytic psychotherapy) that combines the effect of insight and patient/therapist relationship about therapy results. Besides causal studies, PQS has been used to compare the therapeutic process of different psychotherapies,[34,36,37] identify process factors that best predict therapeutic results,[30,38] investigate differences between treatment stages,[39,40] examine psychotherapists' process of formulating clinical hypotheses,[41] determine prototypes of different psychoanalytic and psychotherapeutic treatments,[42,43] among other applications described in the literature.

This article presents the development stages of a Portuguese version of the PQS and describes the preliminary study carried out to verify reliability between different raters after their training. It is part of a larger project, called "Relationship between process and result in brief psychodynamic psychotherapy: a case study," which is an intensive and systematic investigation of a single case, involving application of the PQS in 32 psychotherapy sessions of a depressed patient, whose main objective is to understand the interaction between multiple process variables and therapy outcome.

Method

Instrument

PQS is an instrument based on Q–methodology, also called Q–sort method or only Q–method. Created in 1935 by the physicist and psychologist William Stephenson to study subjectivity from the person's own perspective,[44] this method was later adapted and modified by Block[45] to allow assessments using external judges. Its purpose is essentially to provide a description of an event using Q–sort of a series of items describing an opinion, characteristic, psychological or behavioral aspect of an individual or situation. A particularity of this method is that there is no standard Q–Set. Its objective is precisely to provide a set of elements that best describe variation dimensions of the phenomenon under investigation.[45] Another main characteristic of this method is that items are assessed in relation to each other and not individually.[45,46] This is usually performed with the aid of cards that have the instrument items printed on them, so that they can be ordered in horizontal piles (categories of a predefined *continuum*) on a working desk.[46]

PQS has 100 items presented in individual cards and an explanatory manual with descriptions and operational examples of the items to minimize possible variations in their interpretation.[13] The items can be classified into three large groups: 1) patients' attitudes, behaviors or experiences; 2) therapist's actions and attitudes; 3) patient/therapist interaction or therapeutic climate.[30]

Use of PQS requires training and careful reading of the manual. The application procedure can be thus summarized: after examination of the therapeutic session material and initial formulation about the data, raters (judges) should distribute the cards into nine piles, ranging from a continuum that goes from the less characteristic (category 1) to the most characteristic (category 9). The number of cards in each pile is distributed according to normal curve, ranging from five cards in extremes to 18 cards in medium categories.[13] This forced distribution makes raters search for the best arrangement to describe the phenomena, considering frequency, intensity and importance of an item in relation to the others, which requires time and mental effort.

PQS items were built based on items included in other existing measures of therapeutic process and on items developed by experts. Many versions were tested in pilot studies carried out in hours of psychoanalytic and psychotherapeutic treatments of varied orientations. The items showing little variation between a wide range of subjects and therapeutic sessions, those that were redundant or that presented low interrater reliability were excluded. Item reviews were also performed whenever an aspect of the therapeutic process deemed relevant was not captured by the instrument. The final version proved to be able to assess a variety of phenomena typical of the psychoanalytic process, such as transference, resistance, therapist's interventions and patient's affective states,[39] as well as other theoretical orientations.[30]

Several studies demonstrate that the original version of the PQS has good interrater reliability,[13,30,36] construct validity[30] and discriminant validity.[36] Factorial validity is irrelevant, since this measure presupposes independence between items. In fact, investigations involving factorial analysis of the PQS revealed absence of factorial structure, which is quite desirable from the Q–methodology perspective.[30]

PQS has been translated into Spanish (Ávila Espada ADA, Epstein R, Roussos A, Vidal Didier J, Winkel R, Traducción al español del manual de PQS, Berkeley University of California, 2001), German[40] and Italian.[37] In studies carried out using those versions, there were satisfactory interrater agreement rates.[37,40,41] Furthermore, the study performed by Roussos[41] demonstrated that PQS is a sensitive instrument able to discriminate clinical hypotheses of cognitive and psychoanalytic psychotherapists in segments of the same session. This is an important finding, since the PQS was originally developed to analyze therapeutic sessions as a whole, and not divided into parts.

There is no standard interpretation of results obtained by PQS, since it may vary according to study objectives. Items classified in extremes of Q–sort (more and less characteristic) and/or groupings obtained by procedures of factorial analysis are typically used to obtain summarized descriptions of the therapeutic process (clinical narratives), which can be used in inferential statistical analyses whenever necessary.

Procedures

Authorization to develop and use the Portuguese version of the PQS was granted by the author, Dr. Enrico Jones, through electronic communication in August 2002.

The Portuguese version was developed in four stages. In the first stage, two independent translations of the manual and instrument items were performed by two bilingual psychologists: one of the authors of this article (F.B.S.) and another translator, with vast experience in translation, who had no previous knowledge of the instrument. Next, the consensual version was developed with the help of a psychiatrist, also bilingual, considering both preliminary versions. In some items, one or the other version was chosen and, in others, a combination of both.

The second stage consisted of the back–translation of the consensual version into its original language (English). This stage was performed by a bilingual translator, experienced in translation and back–translation of research instruments, whose native language is Portuguese.

The third stage was the assessment of semantic equivalence carried out by two other authors (M.L.T.N. and C.L.E.), based on the model proposed by Herdman,[47] already used in Brazil by other researchers.[48–50] That assessment considered referential and general meanings. Assessment of referential meaning comprehends assessing to what extent back–translation words refer to the same ideas or objects in the original instrument, i.e., literal correspondence between them. For each item, a visual analogical scale was used, which allowed scoring from 0 to 100%. Assessment of general meaning considered, besides literal equivalence, more subtle aspects of equivalence between both versions (original and version 1), such as maintenance of meaning and impact that certain words or expressions have in the Brazilian cultural context. Items were classified into four categories: unaltered, little altered, much altered and completely altered.

The following stage was discussion, including all authors, of the result of assessments and change of some items to meet the criteria of semantic equivalence. That version, along with the manual, was reviewed by a specialist in Portuguese for small adjustments in writing and verb agreement, resulting in the final version (see Appendix 1).

After the final development of the Portuguese version of the PQS and its code manual, training was given to raters who were supposed to act as judges in the previously mentioned case study. The raters are five psychotherapists with variable clinical experience (between 3 and 14 years). The group is composed of one physician specialized in psychiatry and four psychologists, of which three have formal training in psychoanalytic psychotherapy at a local institution, whose formation model is based on the "tripod": theoretical seminars, supervision and personal therapy.

Raters' training was coordinated by one of the authors (F.B.S.) and carried out in approximately 30 hours, distributed into nine meetings. Initially, there was an intensive and careful study of the PQS manual. Later, transcriptions of four sessions of a brief psychodynamic psychotherapy, other than the main case being investigated, were individually examined by the whole group. The Q–sort of PQS items, in those sessions, was performed by consensus. During training, notes in field diary were made to identify occasional difficulties faced by raters in performing the task and to subsidize complementary data.

Finally, seven sessions of a third case of brief psychodynamic psychotherapy were distributed among recently trained raters, randomized in pairs, so that they could Q–sort the 100 items in the PQS independently. Using Pearson's correlation coefficient, concordance between pairs of raters was then assessed, using coefficients equal or higher than 0.50 as interrater reliability parameter, which is the same criterion adopted in other studies on PQS.[34,38,42,51–53]

Results

In general, items had good equivalence between versions. Of all 100 items in the instrument, 88 had referential meaning above 80%. With regard to general meaning, 91 items were assessed as having identical meaning (unaltered); eight as little altered; and one as completely altered.

Table 1 presents some items that generated more discussion, whether for presenting low referential meaning, or because they presented altered general meaning.

During PQS training, some flaws in terms of understanding and initial handling of the instrument were identified. Among problems concerning understanding is lack of raters' familiarity with some concepts from other psychotherapeutic approaches other than psychoanalysis (for example, in item 80, "therapist presents an experience or event in a different perspective," the concept of "cognitive restructuring" is referred). In discussions performed between training participants, it was mentioned that the PQS manual should have illustrative clinical vignettes in all items, and not only in a few of them. One of the vignettes was considered little appropriate to our reality, although it had not caused problems in item understanding. It is the example that follows item 73 ("the patient is committed to the work of therapy"): " a patient is so interested in beginning treatment that he is willing to give up a weekly golf game to keep therapy appointments." Another important observation was that the group of raters, especially during the first training meetings, presented difficulty in behaving like a neutral observer, which is required in the instrument instructions.[13] In this stage, tendency to interpret the session material was detected, instead of simply describing it.

After the training, a study of interrater reliability was carried out. Of seven sessions, good reliability was found in five (Pearson's correlation coefficient between 0.53 and 0.64) with only two judges. In the other two sessions, it was necessary to include a third rater to produce similar indexes ($r = 0.60$ and $r = 0.72$).

Discussion

With regard to the semantic equivalence study of the PQS, considering both evaluations made, the one concerning the referential meaning had more problems. It is worth mentioning that many items that had low evaluation in terms of referential meaning were considered as having unaltered general meaning, which indicates the existence of some difficulties in back–translating some items that were appropriately translated. This can be explained by the fact that back–translation was performed by a professional unfamiliar with the instrument language, especially words and expressions that represent technical jargon in psychotherapy, and also because this person's native language is Portuguese, and not English. Bearing that in mind, necessary adjustments in translation were performed. And after a final review, both versions, original and translated into Portuguese, were considered equivalent from the semantic perspective.

Since the PQS is an instrument whose application depends on a special training of judges, assessing interrater reliability is recommended whenever it is used. We needed 30 hours of training, distributed into meetings at every 2 weeks for 5 months; between meetings, raters studied the clinical material and performed their individual evaluations for further discussion in the group.

We considered the result of this study encouraging, since evaluation of the therapeutic process using the PQS is extremely detailed, requiring raters' patience and care,[13] besides an obvious considerable amount of intuition and clinical judgment.

It is worth stressing that the group of interraters had variable clinical experience and that there was no bias in the sense of influencing evaluations, whether during the training, whether during the recently mentioned study. Difficulties identified in those moments concern, above all, a higher or lower complexity of phenomena present in the sessions, although there was also some misunderstanding of a few items by raters. As to the first difficulty, there is nothing to be done besides recognizing it and trying to dedicate more time to the study of "difficult sessions," i.e., sessions in which the patient's and/or therapist's mental states and attitudes are not easily

extracted from the written material. This can occur, for example, when non–verbal interaction is prevalent or when the content of the speech is vague, diffuse or chaotic.

To improve item interpretation, we searched for those whose evaluation by the judges was more disagreeing and once again gathered the group of raters to discuss them together. This difficulty seems to be easily overcome by providing more training. On the other hand, since clinical examples were considered essential for full understanding of the items by this group of raters, we planned an adaptation of the manual by including new illustrative vignettes, considering our reality. Adapting the manual to the needs of a given research project, as has been done by other researchers, is a resource that researchers have to increase the instrument's reliability and minimize disagreement between evaluations by different judges.[37]

As to raters' initial difficulties in maintaining a good distance from the material under investigation and in describing the events instead of interpreting them, the authors of the Portuguese version of the PQS believe that it is perfectly understandable and even expected that this occurs, since the group is formed by clinical psychotherapists, and not by researchers. Therefore, all participants had previous experience with reports (memory) of psychotherapy sessions for supervision purposes, a situation in which interpretation is more relevant than description. In addition, none of the raters had previously had the opportunity of examining a report of a recorded session, in which peculiarities of the patient's and therapist's speech (for example, verbal expressions, silences and language lapses) are more accurately captured.

It is known that in memory reports, the text (for example, therapist's interventions) is "lapidated" by the action of the secondary process. Clinical material usually taken to supervision is a reviewed, corrected and censored version of therapy events.[54] In reports recorded by audio or video this alteration is absent, which may cause higher emotional impact on the reader.

Especially at the start of therapy, raters tended to make comments on the adequacy of therapist's interventions (this issue is not assessed by the PQS). This lack of neutrality, recorded in the field diary, is in accordance with the statement made by Sandler & Sandler[55] that the clinical material from recordings often gives the impression, in other colleagues, that the analyst (or therapist, in this case) is a bad professional.

It is important to stress that, as raters were more familiar with the type of clinical material and with the procedures of applying the PQS, more objectivity in performing the task could be achieved. This could be seen both in participants' reports and in the result of interrater agreement.

Conclusion

The study provides to those interested in research on psychotherapy in Brazil the Portuguese version of the PQS, a versatile instrument able to provide empirical and clinically significant information on the therapeutic process of different psychotherapeutic approaches. Such descriptions, compatible with the quantitative analysis, have been used for two decades by many researchers, in varied contexts, in studying the therapeutic process in group study designs and case studies. Application of the PQS requires training, time and mental effort. The preliminary study carried out using the Portuguese version of the instrument demonstrated significant agreement between clinical judgments by different raters. The extensive training previously performed with raters proved to be an essential procedure for proper understanding and handling of the PQS. A review of the manual, concerning illustrative clinical vignettes, could minimize the difficulties found to fully understand some items that reflect concepts that are little familiar to raters.

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Correspondence
Fernanda Barcellos Serralta
Rua Cel. Corte Real, 797/502, Petrópolis
CEP 90630–080, Porto Alegre, RS.
E–mail: psifer@terra.com.br

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† The reference to Dodo's bird veredict ("everyone has won and all must have prizes") at the end of the Caucus–race, quoted from *Alice in the Wonderland*, by Lewis Carroll, was originally made by Rosenzweig, in 1936, in an article in which the author introduces the concept of common factors in psychotherapies.

‡ The instrument was developed by Enrico E. Jones, a psychologist, psychoanalyst, professor and researcher at University of Berkeley, who died in 2003. PQS and its original manual are from 1985. They were first published in 2000, in the appendix of the book *Therapeutic action: a guide to psychoanalytic therapy*.

Appendix 1 - Items of the Psychotherapy Process Q-Set (Portuguese version)

Item 1:	O paciente verbaliza sentimentos negativos (por exemplo, crítica, hostilidade) dirigidos ao terapeuta (*versus* faz comentários de aprovação ou admiração).
Item 2:	O terapeuta chama a atenção para o comportamento não-verbal do paciente, como, por exemplo, postura corporal, gestos.
Item 3:	As observações do terapeuta visam facilitar a fala do paciente.
Item 4:	Os objetivos do paciente no tratamento são discutidos.
Item 5:	O paciente tem dificuldade para compreender os comentários do terapeuta.
Item 6:	O terapeuta é sensível aos sentimentos do paciente, afinado com o paciente; empático.
Item 7:	O paciente está ansioso ou tenso (*versus* calmo e descontraído).
Item 8:	O paciente está preocupado ou conflituado com sua dependência do terapeuta (*versus* confortável com a dependência ou querendo a dependência).
Item 9:	O terapeuta é distante, indiferente (*versus* responsivo e efetivamente envolvido).
Item 10:	O paciente busca maior intimidade com o terapeuta.
Item 11:	Sentimentos e experiências sexuais são discutidos.
Item 12:	Ocorrem silêncios durante a sessão.
Item 13:	O paciente está animado ou excitado.
Item 14:	O paciente não se sente entendido pelo terapeuta.
Item 15:	O paciente não inicia assuntos; é passivo.
Item 16:	Há discussão sobre funções corporais, sintomas físicos ou saúde.
Item 17:	O terapeuta exerce ativamente controle sobre a interação com o paciente (por exemplo, estruturando e/ou introduzindo novos assuntos).
Item 18:	O terapeuta transmite um sentido de aceitação não-crítica (Obs.: a colocação na direção do extremo não-característico indica desaprovação, falta de aceitação).
Item 19:	Existe um tom erótico na relação terapêutica.
Item 20:	O paciente é provocador, desafia os limites da relação terapêutica (Obs.: a colocação na direção do extremo não-característico indica que o paciente se comporta de maneira submissa).
Item 21:	O terapeuta revela informações sobre si.
Item 22:	O terapeuta focaliza os sentimentos de culpa do paciente.
Item 23:	O diálogo tem um foco específico.
Item 24:	Os conflitos emocionais do próprio terapeuta invadem a relação.
Item 25:	O paciente tem dificuldade em começar a sessão.
Item 26:	O paciente experimenta afetos incômodos ou penosos (dolorosos).
Item 27:	O terapeuta dá orientações e conselhos explícitos (*versus* adia, mesmo quando é pressionado a fazê-lo).
Item 28:	O terapeuta percebe acuradamente o processo terapêutico.
Item 29:	O paciente fala sobre querer estar separado ou distante.
Item 30:	A discussão se concentra em temas cognitivos, isto é, sobre idéias ou sistema de crenças.
Item 31:	O terapeuta solicita mais informação ou elaboração.
Item 32:	O paciente adquire uma nova compreensão ou *insight*.
Item 33:	O paciente fala sobre sentimentos de estar próximo ou de estar precisando de alguém.
Item 34:	O paciente culpa outros, ou forças externas, pelas dificuldades.
Item 35:	A auto-imagem é um foco de discussão.
Item 36:	O terapeuta assinala o uso de manobras defensivas pelo paciente; por exemplo, anulação, negação.
Item 37:	O terapeuta se comporta como um professor (de maneira didática).
Item 38:	Há discussão sobre atividades ou tarefas específicas para o paciente tentar fazer fora da sessão.
Item 39:	Existe um tom competitivo na relação.
Item 40:	O terapeuta faz interpretações que fazem referência a pessoas reais da vida do paciente (Obs.: a colocação na direção do extremo não-característico indica que o terapeuta faz interpretações gerais ou impessoais).
Item 41:	As aspirações ou ambições do paciente são tópicos de discussão.
Item 42:	O paciente rejeita (*versus* aceita) os comentários e observações do terapeuta.
Item 43:	O terapeuta sugere o significado do comportamento de outros.
Item 44:	O paciente se sente cauteloso ou desconfiado (*versus* confiante e seguro).
Item 45:	O terapeuta adota uma atitude de apoio.
Item 46:	O terapeuta se comunica com o paciente com um estilo claro e coerente.
Item 47:	Quando a interação com o paciente é difícil, o terapeuta tenta se adaptar, num esforço para melhorar a relação.
Item 48:	O terapeuta estimula a independência de ação ou opinião do paciente.
Item 49:	O paciente tem sentimentos ambivalentes ou conflituados sobre o terapeuta.
Item 50:	O terapeuta chama a atenção para sentimentos considerados inaceitáveis pelo paciente (por exemplo, raiva, inveja ou excitação).
Item 51:	O terapeuta é condescendente ou protetor para com o paciente.
Item 52:	O paciente conta com o terapeuta para resolver seus problemas.
Item 53:	O paciente está preocupado com o que o terapeuta pensa dele.
Item 54:	O paciente é claro e organizado em sua expressão.
Item 55:	O paciente transmite expectativas positivas sobre a terapia.
Item 56:	O paciente discute experiências como se estivesse distante dos seus sentimentos (Obs.: avalie como neutro se o afeto e o envolvimento forem aparentes, mas modulados).
Item 57:	O terapeuta explica as razões por trás de sua técnica ou abordagem ao tratamento.
Item 58:	O paciente resiste em examinar pensamentos, reações ou motivações relacionados aos problemas.
Item 59:	O paciente se sente inadequado ou inferior (*versus* eficiente e superior).
Item 60:	O paciente tem uma experiência catártica (Obs.: avalie como não-característico se a expressão emocional não for acompanhada de uma sensação de alívio).
Item 61:	O paciente se sente tímido ou envergonhado (*versus* à vontade e seguro).
Item 62:	O terapeuta identifica um tema repetitivo na experiência ou conduta do paciente.
Item 63:	Os relacionamentos interpessoais do paciente são um tema importante.
Item 64:	O amor ou relacionamentos amorosos são um tópico de discussão.
Item 65:	O terapeuta clarifica, reafirma ou reformula a comunicação do paciente.
Item 66:	O terapeuta é diretamente encorajador (Obs.: coloque na direção do não-característico se o terapeuta tende a se abster de proporcionar apoio direto).
Item 67:	O terapeuta interpreta desejos, sentimentos ou idéias, rejeitadas ou inconscientes.
Item 68:	Significados reais *versus* fantasiados das experiências são ativamente diferenciados.
Item 69:	A situação de vida atual ou recente do paciente é enfatizada na discussão.
Item 70:	O paciente luta para controlar sentimentos ou impulsos.
Item 71:	O paciente é auto-acusatório; expressa vergonha ou culpa.
Item 72:	O paciente entende a natureza da terapia e o que é esperado.
Item 73:	O paciente está comprometido com o trabalho terapêutico.
Item 74:	O humor é utilizado.
Item 75:	Interrupções ou pausas no tratamento ou o término da terapia são discutidos.
Item 76:	O terapeuta sugere que o paciente aceite responsabilidade por seus problemas.
Item 77:	O terapeuta não tem tato.
Item 78:	O paciente busca aprovação, afeição ou simpatia do terapeuta.
Item 79:	O terapeuta comenta as mudanças no humor ou no afeto do paciente.
Item 80:	O terapeuta apresenta uma experiência ou evento numa perspectiva diferente.
Item 81:	O terapeuta enfatiza os sentimentos do paciente para ajudá-lo a experimentá-los mais profundamente.
Item 82:	O comportamento do paciente durante a sessão é reformulado pelo terapeuta de uma maneira não explicitamente reconhecida anteriormente.
Item 83:	O paciente é exigente.
Item 84:	O paciente expressa sentimentos de raiva ou agressivos.
Item 85:	O terapeuta encoraja o paciente a tentar novas formas de comportar-se com os outros.
Item 86:	O terapeuta é seguro ou autoconfiante (*versus* inseguro ou defensivo).
Item 87:	O paciente é controlador.
Item 88:	O paciente traz temas e material significativos.
Item 89:	O terapeuta age para fortalecer defesas.
Item 90:	Os sonhos ou fantasias do paciente são discutidos.
Item 91:	Lembranças ou reconstruções da infância são tópicos de discussão.
Item 92:	Os sentimentos ou percepções do paciente são relacionados com situações ou comportamentos do passado.
Item 93:	O terapeuta é neutro.
Item 94:	O paciente sente-se triste ou deprimido (*versus* alegre ou animado).
Item 95:	O paciente sente-se ajudado.
Item 96:	Há discussão sobre horários ou honorários.
Item 97:	O paciente é introspectivo, prontamente explora pensamentos e sentimentos íntimos.
Item 98:	A relação terapêutica é um foco de discussão.

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Sociedade de Psiquiatria do Rio Grande do Sul

Av. Ipiranga, 5311/202
90610-001 Porto Alegre RS Brasil
Tel./Fax: +55 51 3024-4846

e-Mail

revista@aprs.org.br